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Assembly
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December 14, 2007

The Honorable James E. Tilton
Secretary, California Department of Corrections and Rehabilitation
1515 S Street, Suite 502 South
Sacramento, CA 95814

RE: Medication Assisted Treatment for Parolees and Inmates Incarcerated at CDCR Facilities

Dear Mr. Tilton:

I am writing you to express my strong support for medication assisted treatment for parolees and inmates incarcerated at CDCR facilities. As Chair of the Assembly Select Committee on Alcohol and Drug Abuse in California, I am committed to finding real solutions and re-shaping California policy on substance abuse treatment. I have made it a priority to address the issue of recidivism among alcohol and drug addicts. I believe that the first step to reducing recidivism is for the State to distinguish between people who have behavioral health issues from people who have criminal issues. To address the issue of recidivism and prison overcrowding the State needs to provide quality evidence based treatment for individuals who struggle with mental health and substance abuse related issues.

In just the last ten years, advances in both the biological and neurobehavioral sciences have brought amazing insights to our understanding of drug addiction. However, there is a tremendous gap between these advances in science and their application through clinical practice and public policy.

In 2006, the California Department of Alcohol and Drug Treatment Programs (DADP) reported that approximately 20,000 people are enrolled in methadone treatment programs across the state. DADP also reports that about 8.5 percent of the current prison population is addicted to opiates. With 170,000 people in California prisons, more than 14,000 could benefit from adoption of methadone treatment in CDCR facilities. Equally important, CDCR could benefit from reduced supervision requirements for 14,000 of its inmates.

Therefore, I am seeking information from you, your General Counsel and Director of Addiction and Recovery Services regarding what changes are necessary to existing statutes in order to implement medication-assisted treatment (MAT) in California's correctional facilities and urge you to consider the advantages of providing opioid addicted inmates and parolees drug replacement therapy.

Background

Methadone is the most widely studied medication and treatment for any disease in the world. Opioid treatment programs provide the dependent individual with an array of rehabilitative services. Therapeutically prescribed doses of methadone relieve withdrawal symptoms, eliminate opiate craving and allow normal functioning. The efficacy of these medications increases significantly with counseling and on-site medical and other supportive treatment services. Medical personnel supervise treatment and nurses administer the medication to patients, most typically on a daily regimen until the individual is stabilized. Patients also provide toxicology samples, which are tested for the presence of methadone and drugs of abuse.

Methadone has been used to treat opioid dependence for thirty-five years and like all medications, therapeutic dosing is contingent upon individual patient needs. Methadone is taken orally and is rapidly absorbed from the gastrointestinal tract, appearing in plasma within thirty minutes of being ingested. Methadone is also widely distributed to body tissues where it is stored and then released into the plasma. This combination of storage and release keeps the patient comfortable, free from craving, and feeling stable.

The General Accounting Office reported in 1990 that "The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, the federal government's two primary agencies for researching drug and alcohol abuse issues, respectively, have concluded that methadone is the most effective method available for treating heroin addiction." Further, the National Academy of Sciences' Institute of Medicine found that *"methadone maintenance has been the most rigorously studied [drug treatment] modality and has yielded the most incontrovertibly positive results... "*.

The National Institutes of Health Consensus Development Conference on "Effective Medical Treatment of Opiate Addiction" (November 1997) concluded that it is necessary to increase access to methadone treatment services throughout the United States and to increase funding for methadone treatment, including providing benefits to methadone patients as part of public and private health insurance programs.

Cost Effectiveness

Cost-benefit studies repeatedly show that the benefits of methadone treatment outweigh the costs. The large California CALDATA (Gerstein, Johnson et al. 1994) study released in 1994 indicated that methadone treatment showed the greatest savings of all existing treatment and recovery modalities studied. The study found a ratio of $10 saved for every $1 invested in treatment. Other studies, usually focusing on single episodes of treatment, report similar findings. A recent study that used a lifetime simulation model suggested that an additional $1.00 spent on increasing treatment yields $76.00 in lifetime

benefits (Zarkin, Dunlap et al. 2005). A more recent study by UCLA published October of 2005 reconfirms this very favorable relationship of short term return on investment in drug treatment. (see http://www.newswise.com/articles/view/515638/)

Ensuring adequate treatment for opiate addicts also reduces supervision requirements of CDCR staff. The model program for providing methadone in prisons is the Key Extended Entry Program (KEEP) at Rikers Island in New York. The KEEP program was implemented in 1996 and has been used as a model for other correctional systems in developing their own programs. An evaluation of the KEEP program by Tomasino, Swanson, Nolan, and Shuman (2001), concluded, among other things that,

> *Anecdotally, the Department of Correction reports a decrease in the use of sick call because inmates are no longer forced into opiate withdrawal. Secondly, KEEP patients have been reported to be less of a management problem in jail because violation of the Inmate Rule Book results in the immediate removal of the patient from KEEP and, ultimately, a detoxification from methadone.*

Another component of cost-effectiveness that is well documented is the success of methadone treatment in preventing recidivism. For example, a study by Ball and Ross (1991) reported that out-of-treatment opiate addicts in six programs committed, on average, more that 200 crime days per year. By comparison, opiate addicts in methadone treatment committed crime less than 40 days per year.

The Tomasino et al (2001) analysis also reported that *"of those methadone treatment patients discharged to the community, mostly to outpatient KEEP programs, 74 – 80% report to their designated program. Recidivism rates reveal that 79% of KEEP patients were incarcerated again only once or twice during a recent 11-year period."* This is an astonishing improvement as compared to the recidivism of untreated opiate addicts.

The Case

The case for providing methadone to opioid addicted inmates and parolees is strong and includes legal, economic and humanitarian reasons:

Legally, California Health & Safety Code section 11222 provides that "In any case in which a person is taken into custody by arrest or other process of law and is lodged in a jail or other place of confinement, and there is reasonable cause to believe that the person is addicted to a controlled substance, it is the duty of the person in charge of the place of confinement to provide the person so confined with medical aid as necessary to ease any symptoms of withdrawal from the use of controlled substances." Section 11222 further states " In any case in which a person, who is participating in a narcotic treatment program, is incarcerated in a jail or other place of confinement, he or she shall, in the discretion of the director of the program, be entitled to continue in the program until conviction." Clearly, these laws intend to ensure safe and humane treatment of people debilitated by illness while in custody; a level of treatment not currently afforded.

In further support of this contention, California Business & Professions Code Section 2051 through 2053 states that a non-physician who "... recommends the discontinuance of legal drugs or controlled substance prescribed by an appropriately licensed practitioner... is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars..." There appears to be no exceptions or exclusions for governmental officials or judicial officers to these prohibitions on the practice of medicine.

Finally, people enrolled in methadone treatment have been deemed by the courts to be protected under Title II of the Americans with Disabilities Act (ADA) and §504 of the Rehabilitation Act of 1973, among others. Thus, failure to provide adequate care to these individuals may trigger a court to order a receiver to evaluate and resolve this issue such as the appointment of a Special Master for health care services in California prisons.

Economically, people enrolled in methadone treatment cost less to supervise than untreated opiate addicts who are incarcerated. Once in custody, opiate addicts experience acute withdrawal symptoms and need to be admitted to special medical facilities within the CDCR setting or they continue to use opiates while in custody creating an increased danger to other inmates and CDCR staff. This ultimatum, of course, does not even begin to contemplate risky sexual behavior or injection drug use which often results in transmission of HIV and Hepatitis C. There simply is no such thing as an opiate addict who stops using opiates and does not either experience withdrawal or continued opiate use. The point is that their untreated condition does not curtail their drug seeking behavior leading to other more serious behavior that requires a higher and more costly security response by the state corrections system.

The last and perhaps most compelling rationale for adopting methadone treatment in CDCR facilities is because it is the morally right thing to do. One former methadone patient told a compelling story of his experience: when arrested for a petty crime such as possession, he was eventually retuned to a CDCR facility where he was in acute withdrawal, experiencing severe cramping, diarrhea, and vomiting. Upon arrival, he was strapped to a gurney and told to 'just deal with it." Certainly, this is not a humane way to treat people with a disease.

In summary, given the broad acceptance of methadone treatment as the "gold standard" for effectiveness in treating opiate addicts as well as the extensive evidence of its cost-effectiveness, why then is it not available to parolees and people in custody in California prisons? I urge you to consider developing and implementing policies to provide medication assisted treatment for parolees and inmates incarcerated at CDCR facilities. Thank you for consideration.

Sincerely,

Jim Beall, Jr.
California State Assembly, District 24

Cc: Chris Khan, Legislative Affairs Secretary, Office of the Governor

Kathy Jett, Director, Reorganized Division of Addiction and Recovery Services, CDCR

Renee Zito, Director, Department of Alcohol and Drug Programs

Robert Sillen, Receiver, California Prison Health Care Receivership Corporation

Sources

Gerstein, D. R., R. A. Johnson, et al. (1994). CALDATA: Evaluating Recovery Services - - The California Drug and Alcohol Treatment Assessment. Sacramento, Ca., California Department of Alcohol and Drug Programs.

Zarkin, G. A., L. J. Dunlap, et al. (2005). "Benefits and costs of methadone treatment: results from a lifetime simulation model." Health Economics **14**: 1133-1150.

Tomasino, V., Swanson, Arthur J., et al. (2001) "The Key Extended Entry Program (KEEP): A Methadone Treatment Program for Opiate-Dependent Inmates." The Mount Sinai Journal of Medicine 68: 14-20.